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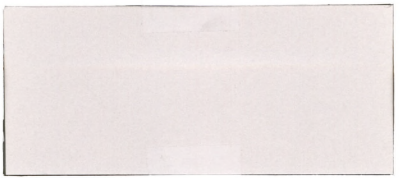

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MEDICAID FREEDOM OF CHOICE:
A Review of Waiver Applications Submitted under Section 2175 of the Omnibus Budget Reconciliation Act of 1981

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I. Background

To relieve the strain which rising health care costs and sharp budgetary reductions have imposed on the Medicaid program, the U.S. Congress recently provided state Medicaid administrators with greater lattitude to operate their programs in a cost-effective manner.

Perhaps the most significant changes in the Medicaid program since its enactment in 1965 are contained in Section 2175 of the Omnibus Budget Reconciliation Act of 1981 (PL 97-35). This section modifies the long-standing program requirement that individual Medicaid recipients have the freedom to obtain services from any qualified provider. This freedom of choice provision was originally mandated by section 1902 (a)(23) of the Social Security Act and codified in federal regulations at 42 CFR 431.51.

Section 2175 of P.L. 97-35 authorizes certain new exceptions to the Medicaid freedom of choice requirement. These exceptions are of two general types. First, under a new section 1915(a) of the Social Security Act, state Medicaid programs will no longer be found out of compliance with federal state plan requirements concerning freedom of choice, statewideness, and comparability of services if a state: (a) enters into certain arrangements to purchase laboratory services or medical devices through competitive bids;* or (b) establishes either a "lock-in" program which restricts for a reasonable period of time the choice of provider by a beneficiary who has overutilized services, or a "lock-out" program which limits the participation of a particular provider within the Medicaid program.

The second way in which states may be exempted from the freedom-of-choice requirement is by obtaining a federal waiver. According to the original version of section 1915(b) of the Social Security Act, which was also added by section 2175, the Secretary of the U.S. Department of Health and Human Services (DHHS) may waive certain state plan requirements contained in sections 1902 and/or the provisions in 1903(m) generally limiting state risk-sharing arrangements to federally-qualified HMOs in order to allow a state to:**

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* A forthcoming publication of the State Medicaid Information Center will examine the issues associated with competitive bidding or bulk purchasing arrangements.

** A provision in a tax bill (H.R. 4961) recently passed by Congress would remove the Secretary's ability to waive the provisions of 1903(m). Presidential approval of this bill is expected in late August or early September 1982. The implications of this statutory change are discussed in Section V of this report.

1. implement a primary care case management system,

2. allow a locality to act as a central broker in assisting Medicaid recipients in selecting among competing health plans,

3. share with recipients, through the provision of additional services, savings resulting from recipients' use of more cost-effective medical care, and

4. restrict recipients to receiving services (other than in emergency situations) from only efficient and cost-effective providers.

One of the often-cited flaws of the health care marketplace is the absence of incentives for individuals to make cost-conscious decisions when utilizing health care services. This situation certainly exists within the Medicaid program, which requires providers to accept the program's reimbursement rates as payment in full and limits the imposition of copayments on certian services and population groups.

The four subsections of 1915 (b) all attempt to increase the importance of price considerations in the decision about when, where, and how to utilize health care services. Each of these subsections, however, can be seen as focusing its efforts at increasing price consciousness on a different actor in the health care decision-making process. Section 1915 (b)(1), for example, which allows states to establish primary care case management systems, places its emphasis upon the primary care physician. These physicians, in carrying out their traditional gatekeeper responsibilities in the health care marketplace, play a very important role in health care utilization decisions. By heightening the primary care physicians' financial involvement in the delivery of all services, primary care networks attempt to increase their awareness of the cost implications of their delivery and referral decisions.

Subsection (2) of 1915 (b) attempts to make recipients themselves more aware of the implications of their utilization decisions by providing them more information about the range of health care options open to them. To the degree that this information will explain fully the advantages which alternative health plans offer (including any additional services cost-effective plans may offer as described below), recipients may become somewhat more cost-conscious in selecting providers. Further, the extent that the localities which will provide this information brokering service act as agents for the state Medicaid agency, there will be an incentive to highlight the benefits to the recipient of selecting a cost-effective provider. In those states in which localities contribute to the non-federal portion of Medicaid expenditures, this incentive will be stronger and more direct.

Subsection (3) also focuses on increasing the cost consciousness of Medicaid recipients by offering them an incentive to select cost-effective providers or treatment modalities, namely, expanded coverage in the form of additional services.

The last subsection, 1915 (b)(4), places upon the state the responsibility for selectively entering into cost-effective arrangements with providers. Although states have always had strong fiscal incentives to promote cost-conscious utilization of services, federal requirements in the past have limited the strategies states have been able to employ to achieve this objective.

The Secretary is authorized to grant waivers of state plan requirements under 1915 (b) only in cases where they are found to be cost effective, efficient, and not inconsistent with the intent of the Medicaid program. These waivers can be granted for a period of up to two years, although a state may request a continuation. Such continuations are deemed granted if a written denial notice is not forwarded to the state by the Secretary within 90 days of submission of the continuation request. Similarly, the conference report accompanying P.L. 97-35 calls for the Secretary to act on the waiver requests themselves within 90 days of submission. The Secretary is further required to monitor the implementation of waivers which are granted and empowered to terminate any waiver when, after notice and oportunity for a hearing, there is a finding of nonconcurrence.

Prior to passage of P.L. 97-35, a number of states, based upon other statutory authority, had already implemented recipient lock-in programs or bulk purchasing arrangements similar to those officially sanctioned by the newly added section 1915 (a). The waiver provisions of 1915 (b), however, offer a significant expansion in the range of major policy options open to states, and raise a whole new set of issues which Medicaid policy makers must address. For these reasons this paper explores the freedom of choice issue through a review of waiver applications submitted to date by state Medicaid agencies under the authority of 1915 (b).

Regulations to implement the provisions of section 1915(b) were published in the October 1, 1981 Federal Register (46 FR 48524) in interim final form. These regulations in general stipulate that a state's written wavier request must include at least the following elements:

- a clear and specific description of the purpose of the waiver in terms of statutorily permitted goals;
- identification of the specific statutory requirements of Title XIX that must be waived to allow the proposed program changes;

- an explanation of the expected cost-effectiveness and efficiency of the program changes, such as the extent to which total Medicaid outlays for the state will be less with the waiver;
- an assessment of how the waiver will affect recipient access to services of adequate quality; and
- a showing that the impact of the waiver on recipients will not be inconsistent with federal Medicaid program objectives.

Certain other requirements, to be described later, are stipulated for specific types of waiver requests. To date, final regulations governing the freedom of choice waiver application process have not yet been issued.

II. The Waiver Approval Process

Two somewhat separate tracks have been established for the submission and review of waiver applications.

Under the "normal" process, waiver requests are submitted by states to the appropriate Health Care Financing Administration (HCFA) regional office. The requests are reviewed at this level and then forwarded, along with the regional office's recommendation, to HCFA central office for further technical review. Final approval or disapproval of the application is made at the HCFA Administrator's level, although disapprovals must have the concurrence of the DHHS Secretary. This final decision is required to be made within 90 days of initial submission of the request, although the need to solicit additional information from the state may extend the review process past this period.

The other path a state's wavier application may take has been termed the "Governor's fast track." Under this scenario the request is transmitted directly to the DHHS Secretary by either the governor or a state cabinet-level official. These applications are reviewed within HCFA central office with the goal of providing a decision to the state within 15 days. Under the "fast track" approach, notice of waiver approvals are made by the Secretary's office. Disapprovals will come from the HCFA Administrator although, again, the Secretary's concurrence is required.

Primary responsibility for the technical review of wavier applications at the HCFA central office level, regardless of what "track" they are on, rests with the Office of Eligibility Policy within the Bureau of Program Policy. This review follows very closely the criteria presented in the interim final regulations which were described earlier in this report. The majority of freedom-of-choice waiver applications submitted to date are relataively short documents (most being several pages each, some with attachments). They are generally divided into the following five sections which correspond to the informational requirements called for in the regulations:

1. Purpose. The project for which waivers are requested is described.

2. Statutory Provisions to be Waived. The state identifies which state plan requirements of section 1902 and/or 1903(m) it wishes to have waived. It should be noted that HCFA review guidelines emphasize that waiver of a particular requirement must actually be necessary in order to implement the proposed project.

3. Cost-Effectiveness. A brief rationale of the anticipated cost effectiveness of the proposed project is presented. An example would be "Expected savings will result from more cost-effective selection of hospitals, reduced outpatient hospital utilization, shorter hospital stays, and reduced use of emergency rooms for non-emergent care." Specific dollar and cents estimates of savings are not required.

4. Service Access. A brief assessment of the effect of the project on recipient access to quality care is given. For example, "Access may actually be increased, as recipients will be guaranteed 24-hour access to a primary care physician."

5. Consistency with Medicaid Program Objectives. A short statement is provided affirming the fact that the goals of the project are consonant with the overall objectives of the Medicaid program.

A discussion of the waivers which have already been submitted to HCFA will illustrate how states are addressing the above set of criteria in their waiver applications.

III. Waiver Requests

As of early August 1982, thirty freedom-of-choice waiver requests had been received by HCFA central office from a total of fifteen states. These requests can be catalogued to some extent according to the particular subsection of 1905 (b) through which authorization for waivers is sought. The states submitting these waivers as well as their current status are identified in Table 1, which groups them based upon either a reference to a specific provision within the application itself or HCFA's preliminary classification of the requests when received.

These waiver requests seek to achieve a wide range of goals ranging from increasing the responsibility of primary care physicians for the care of their patients to the imposition of copayments on mandated Medicaid services. It is apparent from the nature of requests submitted that states have been most interested and successful in designing approaches to place more responsibility on primary care physicians for the overall health care utilization of their Medicaid patients. Of the thirty waiver applications received by HCFA at the time of this writing, eighteen, or 60%, have been submitted under the primary care network authority of 1915 (b)(1) (See Table 1). The applications submitted under the provisions of the subsection range from several requests from states seeking to "lock-in" HMO enrollees for their first six months to a proposal to establish statewide case management programs.

More important, however, is the fact that of the seven waiver applications which have been fully approved by HCFA, all had been submitted under the authority of 1915 (b)(1). A portion of an eight application was also approved, allowing a state not to apply its copayments requirements to HMO enrollees.

Two of the approved case management projects would require Medicaid recipients in a certain area of a state to enroll in an HMO. The other five offered recipients a choice of primary care providers from which they could select a case manager. In three of these five projects recipients are required to enroll with a primary care case manager; in the other two, this decision was left to the recipient.

The financial incentives offered to the primary care case manager varied across these approved waiver projects. At least half will establish capitation rates set at or below 95-100% of average area fee-for-service levels. A monthly case management fee is to be paid to primary care providers in one project, while in another the state will share savings in inpatient hospital expenditure with the primary providers.

Table 1

STATUS OF MEDICAID FREEDOM OF CHOICE WAIVER APPLICATIONS

Authority	CA	CO	CT	HI	ME	MA	MI	MS	NH	NJ	NY	PA	UT	WA	WI	Totals a	d	p	w	Comb.	Total
1915(b)(1): Primary care case management	p	1-a 1-p		p		2-p	2-a 1-p		a		p	1-a 1-p	a	2-d	1-a 1-d	7	3	8	0	0	18
1915(b)(2): Localities serving as brokers																					
1915(b)(3): Sharing of cost savings with recipients			d						d						1-w/d/a 1-w 1-d	0	3	0	1	1	5
1915(b)(4): Restricting recipients to cost effective providers	p										p			p	d	0	1	3	0	0	4
Unspecified					d			d		d						0	3	0	0	0	3
																7	10	11	1	1	30

Note: Table indicates number and status of waivers requested by states as of August 4, 1982. When only the status is given, the state has submitted only one waiver request in that area. Where more than one status is indicated for one proposal, different decisions were made concerning the various aspects of that proposal.

Code: a - Approved by HCFA
d - Disapproved by HCFA
p - Pending decision by HCFA
w - Withdrawn by state

Four of the requests which have been disapproved have sought waiver of restrictions on the amount and/or application of recipient copayments. The others all sought waivers for purposes which HCFA found to be outside the scope of the provisions of 1915 (b). Table 2 on page 34 summarizes certain aspects of the programs proposed in the states' waiver applications, while Table 3 on page 38 identifies the specific state plan requirements for which each application seeks waivers. More detailed descriptions of individual waiver requests, drawn directly from the applications themselves, are presented in the following paragraphs.

A. Primary care case management systems

Eighteen applications from eleven states have sought waivers under the statutory authority provided by section 1915 (b)(1) to establish some form of primary care case management system within their Medicaid programs. In general, this is a relatively new health care financing and delivery structure which increases the responsibility of primary care physicians for the overall management of their patients' care, and makes physicians more aware of the financial implications of their decisions. In establishing this increased responsibility, recipients are restricted to a particular provider for obtaining primary care services and for authorization to receive certain other services.*

In order to firmly establish this primary provider-recipient relationship, federal regulations specifically stipulate that states applying for a case management system waiver must provide assurances that a specific person or agency will be responsible for locating, coordinating, and monitoring Medicaid services on behalf of the recipient.

Descriptions of the applications submitted under the authority of 1915(b)(1) are provided below.

1. California

The California Department of Health Services on June 25, 1982, submitted to HCFA a waiver application to allow Medicaid funding for the activities of On-Lok, a community-

* A more detailed discussion of primary care case management systems and their applicability within state Medicaid programs can be found in the NGA publication, Medicaid and Primary Care Networks: A Concept Paper and the Proceedings of the NGA Conference on Medicaid and Primary Care Networks/Case Management System, March 1982.

based comprehensive care organization in San Francisco. While the application identifies 1915 (b)(1) as the principal legislative authority for securing the requested waivers, the provisions of 1915 (b) concerning use of a locality as a central broker and the sharing of cost savings with recipients are also cited as the basis for the proposal.

On-Lok has operated since 1971 through funding from a series of federal grants. It provides a wide range of medical, social, and supportive services primarily for elderly individuals who have been certified by the state as being in need of skilled nursing facility care. With the federal grants coming to an end, the organization now seeks to become a prepaid capitated health plan supported principally through Medicare and Medi-Cal (California's Medical program) reimbursement. This waiver application seeks approval for the Medi-Cal program to enter into a contractual agreement with On-Lok for the provision of its broad service package to Medi-Cal recipients.

Based upon On-Lok's experience, significant cost savings are anticipated from Medi-Cal contracting with this organization. A comparison of On-Lok's per unit costs over the past three years with other populations show a range of savings per recipient from $359 when measured against Medi-Cal Institutional Non Grant Aged costs, to $1494 when measured against costs for the Medi-Cal share for elderly patients in the county skilled nursing facility in San Francisco.

No decision has yet been reached by the federal government on this waiver request.

2. Colorado

The State of Colorado has submitted two applications under 1915 (b)(1). After receiving approval to implement the first proposal, however, the state decided to alter its program substantially and therefore submitted a second application. The first application was submitted on January 25, 1982, requesting waivers of its Medicaid statewideness and freedom-of-choice state plan requirements in order to establish a program in Mesa County, Colorado, under which Medicaid recipients would be required to select a physician from among those associated with the Rocky Mountain Health Maintenance Organization.

The state has contracted with the Rocky Mountain HMO for seven years, with 60% of the Medicaid recipients in Mesa County already voluntarily enrolled. Ninety percent of the physicians in the county are also associated with the HMO, as are 100% of the hospitals and 95% of the pharmacies. Twenty-four hour access is provided to enrollees by the HMO.

Colorado will reimburse the HMO for coverage of its Medicaid recipients on a prepaid capitated basis, with the agreement that the total cost will not exceed 95% of the average area fee for service cost for Medicaid recipients. It is estimated that the cost of the state's contracts with HMOs have been 10% to 20% lower than comparable fee for service rates, and that its contract with the Rocky Mountain HMO has saved the state approximately $1 million over the past seven years.

The Colorado waiver application was approved by DHHS on March 3, 1982. The notification indicated that approval was granted with the understanding that restrictions were not placed on recipients' access to emergency services and that recipients' HMO disenrollment rights under section 1903 (m)(2)(A)(vi) were not affected.

After this application was approved, however, some concern arose within the state that, in spite of the fact that such a high percentage of physicians in the county were associated with the HMO, mandatory enrollment would force some recipients to give up long-standing relationships they had developed with their own physicians. As a result of this concern, Colorado subsequently notified HCFA that it would not implement the program outlined in its waiver application. Instead, the state on June 15, 1982, submitted a second waiver application which would establish a broader primary care physician case management program.

Under this new program, Medicaid recipients would be offered a choice of primary care providers rather than being automatically enrolled in one HMO. All recipients, upon eligibility determination, would have a period of open enrollment (possibly 2-3 months) during which time they would be required to select a primary physician from among the available HMOs and other primary care providers (either a physician, a group of physicians, or a clinic) participating in this program.

This physician case manager will render primary care and accept overall responsibility for the recipient's health care, guaranteeing 24-hour access arrangements and authorizing, coordinating, and monitoring all visits to other physicians, lab and x-ray services, and inpatient and outpatient hospital services (except emergency services). It is Colorado's intention to implement this program statewide, although a waiver of statewideness is sought because it may not be possible to implement the program in some areas where there may be a lack of physician participation.

The development of this program was mandated in the state's budget bill passed during the 1982 legislative session. This bill also establishes the Physicians Incentive Pool as an incentive for physicians to participate in this case management program. This pool is an appropriated sum of money which is set aside to increase the level of reimbursement to physicians from 55% to 75% of billed charges if savings in outpatient and inpatient hospitalization costs are realized. Reimbursement would occur on a unit-for-unit basis, with the size of the retroactive rebate made to primary care physicians based upon the amount of services they have provided. If savings are not realized, the incentive pool will serve as a built-in supplemental to cover cost overages as they occur in the hospitals. Overall annual savings to the state resulting from this program are estimated to be three million dollars.

No federal decision has been made by HCFA on this second Colorado waiver application.

3. Hawaii

The State of Hawaii on June 14, 1982, submitted a waiver request under the general authority of 1915 (b). This application, prepared at the suggestion of the Kaiser Foundation Health Plan, Inc., seeks a waiver of the confidentiality requirements of 1902 (a)(7) to allow the state to provide Kaiser with a listing of eligible AFDC recipients.

This list would be used for the sole purpose of contacting these recipients and informing them of their eligiblity for enrollment in the Kaiser HMO through its contract with the state Medicaid agency. During the first few years of its contract with Kaiser, which began in 1971, the state provided the health plan with monthly printouts of AFDC eligibles. Kaiser personnel then contacted these individuals by letter to explain the HMO plan and invite further inquiries. Changes in federal requirements made in the mid-1970s brought an end to this practice.

No decision has yet been reached on Hawaii's request.

4. Massachusetts

The state of Massachusetts has submitted two applications concerning primary care case management programs.

The first application, submitted on July 19,1982, seeks to continue and expand the state's case management program which had operated since 1979 under federal research and demonstration waivers granted under Section 1115 of the Social Security Act. Under this program recipients may opt to obtain their primary health care from participating providers such as HMOs, clinics, and neighborhood health centers which have been screened by the state for quality of services and financial accountability. Once recipients have enrolled with their chosen health care provider, they select a primary physician who is responsible for case management. This physician provides all primary care and monitors and arranges any additional care such as laboratory tests, x-rays, specialist consultations, and inpatient hospital care. Recipients will have 24-hour access to their primary care physicians.

HMOs which participate in this program will receive a risk-based capitation payment which will be set below regional average fee-for-service costs. Other participating primary health care providers, in return for monitoring and arranging needed care, will receive regular Medicaid fee-for-service reimbursement and share any savings which accrue as a result of the program. After the program's first year, these primary providers will also be at risk for the total amount spent and will have to repay the state for a portion of any losses incurred.

Because there may be areas in the state where participating primary care providers will not be available, Massachusetts has requested a waiver of the Medicaid statewideness requirements. In addition to this, the state has also requested waiver of the freedom of choice requirement and of the provision which precludes states from contracting on a risk basis with an entity which is not a federally qualified HMO.

A second waiver application was submitted by Massachusetts on July 21,1982. The state proposes to have a private non-profit organization--The Commonwealth Health Care Corporation (CHCC), which is made up of a group of Boston hospitals and health centers--provide coverage for the categorically and medically needy AFDC-related Medicaid population in the City of Boston through a primary care case management network of providers.

Under this program of Managed Health Care, CHCC will:

- enter into a contract with the state to provide services for Medicaid recipients covered unter the program on a risk basis for a multi-year period. CHCC will receive a fixed monthly payment per enrollee equal to the state's FY 1982 Medicaid expenditure level per Boston AFDC recipient;
- enter into contracts with a series of member institutions and other providers to provide services to the Medicaid eligibles, again on a risk basis. Such institutions and providers will form networks capable of meeting the basic service and administrative requirements and will be known as "COREs"--Coordinated Operating and Reporting Entities;
- work with the state to enroll eligibles into individual COREs, ensuring that eligibles have free choice among COREs;
- maintain data systems to process claims from contracted COREs and providers, to monitor utilization, and to create data files for entry by the state into its MMIS system in order to provide consolidated MARS and SURS reporting; and
- perform certain utilization review and quality control functions.

In order to implement this program, Massachusetts has requested waivers to:

(1) restrict recipients' freedom of choice of provider. Once recipients have selected a primary care provider they will be able to switch only during certain periods;

(2) permit CHCC to contract on an at-risk basis with non-federally qualified HMOs with more than 75 percent of their members being Medicaid and Medicare recipients; and

(3) guarantee for all primary care case management providers six-month eligibility for Medicaid recipients enrolled in their care. While this is normally allowed only for federally-qualified HMOs, the state believes that extending this guarantee to other primary care providers will improve program coordination and increase provider participation.

The program's timetable calls for an approximately four-month planning process followed by a six-month implementation period. This will provide CHCC adequate time to enter into subcontracts with providers and to establish its data systems and administrative procedures. This six-month period will also allow enrollment efforts to coincide with the state's eligibility redetermination process.

At the time of this writing, the federal government had not reached a formal decision on either of Massachusetts' waiver applications.

5. Michigan

The State of Michigan's Department of Social Services has submitted three waiver requests under the primary care case management authority of section 1915 (b)(1).

Michigan submitted its first waiver application on November 5, 1981, in order to establish its Primary Care Physician Sponsor Program (PCPS) in the Detroit area (Wayne County). Under this program, all Medicaid recipients in the area would select a physician sponsor from among available physicians participating in the program. These physician sponsors will serve as the case managers for the recipients enrolled with them. The physician sponsor will provide primary health services and accept the responsibility for the recipient's total health care, guaranteeing a 24-hour access arrangement and authorizing, locating, coordinating, and monitoring all visits to other physicians, laboratory and pharmacy services, and hospital services (except emergency services).

Sponsoring physicians will receive from the state periodic reports on the services received by their sponsored recipients to facilitate effective monitoring of care. The sponsoring physician will be reimbursed at the usual fee for service rates plus a monthly case management fee of $3 for each recipient. Michigan estimates that the physician sponsor program might reduce the cost to the state of providing care for enrolled recipients by 7 to 10% if the program's performance parallels the state's experience with HMOs.

All Medicaid providers offering primary care (e.g., general practitioners, family practitioners, internists, and pediatricians) will be eligible to participate in this program. They will be required to meet Medicaid standards for quality and cost of care; providers who are found to not meet established standards for utilization and total costs of care may be sanctioned or terminated from the physician sponsor program. With proper notice, recipients will be allowed to change physician sponsors.

This application was approved by the Health Care Financing Administration on Febraury 9, 1982. The approval letter reiterated the state' assurance that implementation of the program will begin only when there is sufficient physician participation in the program to ensure adequate recipient access to quality services.

Since receiving approval of its waiver request, Michigan has encountered some problems in implementing its program. Concern was expressed by some providers over the state's proposed policy of terminating from the PCPS program without a hearing primary providers whose patients overutilized services, as well as the limit it set of 1500 recipients per primary sponsor. As a result, a temporary restraining order was imposed on the implementation of the program. A ruling by the court is expected shortly.

The second Michigan waiver application was submitted November 25, 1981, and has also been approved. This request sought to establish a statewide case management program called the Capitated Ambulatory Program.

Under this program recipients will be given the option of obtaining most of their primary health care from a specific provider who will receive a capitation payment to be responsible on a risk basis for providing a negotiated package of medical benefits. All Medicaid enrolled clinics or groups of physicians offering primary care will be eligible to participate as providers under this program. Recipients entering the program will be allowed to select their provider and, once enrolled, may change providers, but only with proper notice.

Participating providers will be required to contract with the Medicaid program to provide a comprehensive health care package which includes offering 24 hour access to health services and taking responsibility for locating, coordinating, and monitoring service on behalf of the recipient. These providers will be paid an agreed upon capitation rate for their services, which is not to exceed 100% of projected fee for service charges.

Michigan estimates that if the capitated ambulatory program produces savings similar to those experienced with its HMO contracts, inpatient hospital utilization may be reduced approximately 20%. This would result in an overall savings to the program of 10% on inpatient care, since the state anticipates sharing its savings with enrolled providers.

In addition to seeking a waiver of the freedom-of-choice provision of Title XIX, Michigan also requested in this application a waiver of the requirement that no more than 75% of the prepaid membership of an entity be Medicaid recipients. Because the capitated ambulatory program will be established on a special contractual basis between the state Medicaid agency and participating clinics and groups of physicians which will include

incentive provisions for reducing hospital utilization, these participating providers would not be expected to offer the same option to the general public. The state therefore anticipates 100% of the clients participating in the capitated ambulatory program to be Medicaid recipients, with the clinics and physician groups participating in this program continuing to provide services to private patients on a fee for service basis.

Michigan's final freedom-of-choice waiver application was submitted on December 14, 1981. This application seeks a waiver of the requirement found in section 1903 (m)(2)(A)(vi) of the Social Security Act which stipulates that Medicaid recipients must be allowed to terminate enrollment with an HMO or prepaid health plan without cause as of the beginning of the first calendar month following a full calendar month after the recipient requests disenrollment.

Michigan has requested this waiver to allow it to continue a previous policy of requiring Medicaid recipients enrolling in HMOs or prepaid health plans (PHPs) to remain in the HMO or PHP for a period of 3 months immediately following the initial month of enrollment. During the first month enrollment, recipients may request disenrollment. This procedure has been in effect within Michigan from the time it first began contracting with HMOs until October 1, 1981, when the policy was prohibited by P.L. 97-35.

The application stresses the importance of reinstituting this policy, explaining that HMOs and PHPs provide preventative health care through education and health mainte nance. To accomplish their goals, these organizations need time to reeducate recipients about better health care patterns before cost savings are realized from more appropriate utilization. It is argued that reversing patterns--such as inappropriately using emergency room care, doctor shopping, and focusing on episodic, curative care rather than preventative services--which have been developed by obtaining care in the fee for service sector requires a period of time of restricted freedom to establish and enforce this learning process.

No decision has yet been reached by HCFA on the third Michigan waiver application.

6. New Hampshire

The State of New Hampshire requested waivers on March 26, 1982, in order to establish a primary care case management program.

Under the state's proposed approach, an estimated 2,000 Medicaid recipients would be automatically enrolled in the Matthew Thornton Health Plan, an HMO operating within the state. Those individuals who meet the following criteria would be enrolled in the HMO:

- they are eligible for Medicaid through the AFDC or AFDC-foster care programs, or the state's CFS program which covers children for whom public agencies are assuming full or partial financial responsibility and who are in foster homes or private child-caring institutions;
- they reside in the HMO's catchment area; and
- they are served by the state Division of Welfare's Nashua District Office.

Each enrollee will select a primary physician within the HMO who will be responsible for locating, coordinating, and monitoring services on behalf of the recipient.

The services to be provided to these enrollees would be identical to those provided other group plan enrollees and are more expansive than those available under the state's current Medicaid state plan. Coverage is provided for emergency services delivered outside the plan.

Recipients may appeal the automatic enrollment into the HMO. The basic criteria for determining whether there is good cause for not requiring enrollment will be a demonstrated long term relationship with a particular physician for treatment of chronic or acute illness, as well as some indication that the recipient's health and well-being will be negatively affected by the transfer to a new physician. Once in the HMO, recipients will not be allowed to terminate enrollment without good cause. Termination will be allowed for reasons such as the recipient's moving from the catchment area, ineligibility, or the inability to establish a harmonious physician-patient relationship, in this last case when termination is requested by the HMO and approved by the state Medicaid agency.

The New Hampshire application was approved by HCFA on June 1, 1982, with implementation of this case management system scheduled to begin in January 1983, when construction of the HMO's new facility is completed. The HCFA letter noted that approval was made with the understanding that restrictions on recipient disenrollment privileges will not exceed six months.

7. New York

On February 18, 1982, the New York State Department of Social Services submitted a freedom-of-choice waiver application. Similar to the State of Michigan's third waiver request, New York is seeking permission to waive the state plan requirement which allows Medicaid recipients to disenroll from HMOs at any time without cause.

New York proposes to return to its previous policy of allowing Medicaid recipients who voluntarily enroll in HMOs to disenroll for any reason during the first 30 days after enrollment. During the next five months, however, the individual would be allowed to disenroll only for good cause, through a written grievance procedure in the state's Medicaid/HMO contract. This policy would apply only to new enrollees to federally qualified or state certified HMOs.

Like Michigan, New York points out that this restricted disenrollment policy is needed to provide the HMO with the opportunity to "make its case" by demonstrating the benefits of continuity of care and allowing the Medicaid enrollee sufficient time to become familiar with the HMO and its services. The enhanced financial attractiveness of the HMOs contracting with the state for coverage of Medicaid enrollees was also highlighted.

No decision has yet been reached at the federal level concerning the New York waiver request.

8. Pennsylvania

The State of Pennsylvania has submitted two freedom-of-choice waiver applications. The first application, dated March 4, 1982, requests authorization to establish a case management program for individuals who have been receiving medical services at a frequency or amount which is not medically necessary. These "high utilizers" would be identified based upon profiles generated by the surveillance and utilization review subsystem (S&URS) of the state's Medicaid Management Information System (MMIS).

To achieve more appropriate utilization patterns, these individuals will be required to select a physician who will provide primary care to the individual as well as authorize, coordinate, and monitor medical services to be received from other providers. In the event the recipient cannot locate a primary care physician to assume this case management

responsibility, the state will assign one. With the exception of emergency, dental, and transportation services, no other practitioner would be reimbursed for any services rendered to restricted recipients without a written referral from the primary care physician.

As an incentive for the primary care physicians to participate as case managers under this program, Pennsylvania proposes to pay each of them $10 per month for every restricted recipient under his or her care, in addition to reimbursement for any services rendered directly by the physician.

The state currently has 2,200 recipients enrolled in a pharmacy "lock-in" program. The estimated cost of paying primary care physicians an additional $10 per month for these restricted recipients would be $264,000 per year. Pennsylvania estimates, however, that implementation of this Case Management Program would produce overall savings of $2.2 million per year.

No decision has yet been reached by the federal government on this waiver request.

Pennsylvania's second application, submitted on April 27, 1982, on the governor's fast track route, seeks to establish a case management system called the Primary Care Capitated Program (PCCP).

The state plans to begin this program with four primary care centers selected through a competitive bid process by the State Department of Health. These centers will provide coverage of all services under the state's medical assistance plan, with the exception of long term care. The centers will offer 24-hour coverage for primary care and provide for out-of-area emergency services. The centers' providers will act as case managers, controlling and monitoring all health care usage including referrals to specialists, inpatient hospital care, drugs and medical supplies, lab services, etc.

The centers, which currently serve Medicaid recipients on a fee for service basis, will receive capitated payments on an at-risk basis for individuals enrolled under the Primary Care Capitated Program. The capitated rates will be individually negotiated with each center, although in no case will they exceed 95% of the cost of comparable care purchased on a fee for service basis. Because these centers are neither federally nor state approved HMOs, Pennsylvania is requesting that the requirements of section 1903(m)(2)(A)(i) be waived to allow capitation on a risk basis. The centers will be subject to the same quality of

care audits the state employs for federally qualified HMOs; the state's model agreement with HMOs will also be used for contract purposes.

Medicaid recipient participation in this program will be voluntary, with an anticipated enrollment of 4,000 in the four centers. Individuals will be free to disenroll for any reason during the first 30 days; however, Pennsylvania is seeking a waiver to restrict disenrollment past that date to instances of loss of Medicaid eligibility, documented disagreements with the center over care issues (e.g., failure to establish a satisfactory physician-patient relationship), or mutual consent. A waiver of 1903(m)(2)(A)(ii) is sought in that only Medicaid recipients will be enrolled in the centers on a prepaid basis. The remaining 75% of the centers' caseload will be a mix of public and private patients receiving care on a fee for service basis.

The Department of Health and Human Services approved Pennsylvania's application to establish the Primary Care Capitated Program on June 30, 1982. The approval letter reiterated the fact that the waiver does not permit restrictions on recipients' choice of proviers for emergency services.

9. Utah

The State of Utah on November 2, 1981, submitted a request for the waivers necessary to establish a case management system. This request was supplemented by additional information provided HCFA in correspondence dated January 25, 1982.

Utah sought waivers to address the problems recipients face in some parts of the state in locating physicians for Medicaid recipients. Statistics indicate that only 20% of the state's physician population will treat Medicaid clients. As a result, these clients are forced to seek care in more accessible, and yet more costly, hospital outpatient departments and emergency rooms.

Under the state's case management program Medicaid recipients would be required to select a central source of health care from among three alternatives:

- HMO Utah - a prepaid health delivery system structured along the independent practice association model and sponsored by Blue Cross/Blue Shield of Utah

- Family Health Program - a certified HMO
- A primary care physician reimbursed on a fee for service basis.

Because of Utah's large rural areas, all three of these choices will not be available to all recipients. In those areas where one or two of these options are not available, recipients will select their central provider from a list of primary care physicians. The State Health Department and the Department of Social Services would act as a central broker in assisting individuals in selecting an appropriate alternative. A pilot project would be established in Ogden, Utah, using assistance payments intake workers to help recipients make informed choices. Because of this aspect of the case management program, the state also cited as the legislative basis for its request section 1915(b)(2) which authorizes the granting of waivers for localities to provide such brokerage services. Section 1915(b)(4), which allows waivers to restrict recipients to cost effective providers, was also referenced as a possible statutory authority for approving the state's application.

Whichever alternative is selected, the primary provider will provide primary care services to its enrolled recipients and will be responsible for making referrals for specialty care using a special referral form. The primary provider, who is to provide 24 hour telephone coverage, is to be contacted prior to a client's seeking emergency care. In life threatening situations or in cases where the primary provider cannot be reached, the client is instructed to go directly to the hospital emergency room, with the primary provider to be contacted as soon as possible.

On March 23, 1982, Utah received from DHHS approval of its waiver request under 1915(b)(1) for a period of two years. This notice included authorization to utilize the central broker concept as part of the case management system. It was also stated that approval under 1915(b)(4) was not needed.

10. Washington

The State of Washington has submitted two waiver applications under the authority of section 1915(b)(1).

The first application, submitted on October 16, 1981, sought the waiver of certain Medicaid regulations governing nursing home utilization control/review activities. This request was disapproved by HCFA, which stated that the proposed changes did not meet the definition of a case management system.

Washington's second application requested a waiver in order to implement a $5 copayment on emergency hospital services and outpatient department visits for all Medicaid recipients, except those residing in institutions. HCFA also disapproved this second application, citing the fact that the freedom-of-choice provisions of the Omnibus Budget Reconciliation Act provided no statutory authority to approve waivers for copayments.

11. Wisconsin

On February 8, 1982, the State of Wisconsin submitted a set of six waiver proposals under the authority of section 1915(b). One of these applications requested waivers to establish a program under which recipients would be required to select from among available prepaid capitation arrangements--such as HMOs or other cost-effective primary care provider or case-manager arrangements--with which the state Medicaid program will have contracts.

The program will be phased in gradually, beginning with four of the state's most populous counties. In areas where two or more such prepaid plans or arrangements are available, each recipient will be asked to choose a primary physician from those participating in these plans from whom to receive all primary care and who will provide or refer for other needed care. In areas where only one such prepayment option is available, recipients will be automatically enrolled unless an individual elects to "opt out." Five of the six HMOs with which the state is currently negotiating are "independent practice association" models, with which a significant number of the areas' primary care physicians are affiliated. Local social service departments may be used to assist recipients in selecting from competing plans or, if only one is available, in deciding whether or not to opt out of the plan in their area.

Under this program, recipients would not be allowed to leave the prepaid option for a fee-for-service arrangement without good cause. Recipients would not be prevented from moving from one acceptable prepaid arrangement to another, provided reasonable notice is given or the change is made during a prespecified time, such as an annual open enrollment period. In order to make the prepaid arrangements more attractive to recipients, however, Wisconsin requested in another application a waiver to exempt prepaid plan enrollees from any of the state's copayment requirements.

On May 12, 1982, Wisconsin was informed by the Department of Human Services that the waivers requested for this program were approved under the authority of 1915(b), although it was noted that these waivers do not authorize the state to restrict recipients to specific providers under emergency circumstances. As will be discussed in a later section of this report, the Department also approved under 1915(b)(3), the state's request to share with recipients the savings from use of cost-effective HMO providers through elimination of the state's cost-sharing requirements on HMO services and the provision of additional services.

A second application was submitted by Wisconsin under the authority of 1915(b)(1) in order to implement a program under which local mental health boards would assume gatekeeping responsibility for authorizing inpatient psychiatric care and outpatient mental health services, including those provided by a psychiatrist. This waiver was denied by HCFA, which found no statutory authority in 1915(b) for approving it.

B. Localities Serving as Brokers

Section 1915(b)(2) of the Social Security Act, established by P.L. 97-35, provides the authority for certain Medicaid state plan requirements to be waived in order to allow localities to act as central brokers in aiding recipients to select among competing health plans.

To date, no state has cited this provision as the principle legislative authority under which a waiver application has been submitted. Wisconsin's proposal to establish a program to enroll recipients in prepaid capitation plans indicated that the local health and social service departments would assist recipients in selecting from among the options available to them but did not cite 1915(b)(2) as the statutory authority for requesting any of its waivers. Only the State of Utah's application to establish a case management system, which was described earlier, referenced this provision in discussing the role local intake workers would have in assisting recipients in selecting a primary care provider. HCFA's subsequent notice of approval in response to Utah's application indicated that a waiver under the provisions of 1915(b)(2) was not needed.

C. Sharing of Cost Savings with Recipients

Subsection (3) of 1915(b) authorizes the federal government to grant waivers to states which elect to share with their Medicaid recipients, through the provision of additional services, savings resulting from recipients' use of more cost effective medical care.

HCFA received applications from three states which were viewed as seeking waivers under the authority of this provision.

1. New Hampshire

The first of these applications was submitted on November 10, 1981, by the State of New Hampshire. The state was seeking permission to reimburse directly for services provided to institutionalized individuals, even in cases when the services would exceed the limits set for non-institutionalized individuals. The application also inlcuded a request to impose a $10 copayment on outpatient department visits and a $3.50 copayment on individual prescriptions. Institutionalized individuals would be exempt from the copayments. HCFA rejected this application noting that there was no statutory authority for the granting of waivers for copayments and that the request did not meet the necessary criteria for any of the four freedom-of-choice waiver provisions.

2. Connecticut

The second waiver request in this category was submitted by the State of Connecticut on December 3, 1981. This application also requested a waiver to impose a larger copayment on taxi and livery services than is permitted under current regulations. This copayment would not be imposed if a physician certifies that the individual needs repeated trips to a practitioner or facility or that a taxi or livery is the medically required type of transportation. This application was also denied by HCFA.

3. Wisconsin

Among the package of waiver applications submitted by the State of Wisconsin on February 8, 1982, were several which focused on the issue of recipient cost sharing. The first of these waiver requests sought to exempt the following groups of recipients from the state's copayment requirement:

- medically needy and categorically needy persons residing in nursing homes
- recipients enrolled in prepayment plans
- categorically eligible children in a subsidized adoption or foster care placement, and
- all children receiving services as the result of an EPSDT screen.

In addition, the state in this application requests a waiver to: 1) provide certain option benefits to medically needy nursing home residents above and beyond those services provided to the non-institutionally categorically needy, and 2) phase out coverage of lower levels of ICF services limiting this case to only those individuals presently receiving it or who have a primary diagnosis of developmental disability or chronic mental illness. The state explained that the optional services to be provided to the medically needy nursing home residents were those frequently required as part of the patients' plan of care. All the modifications in the state's Medicaid plan sought under this waiver application were mandated by state statutes passed in 1981.

On May 6, 1982, Wisconsin withdrew its request for a waiver to provide certain optional services to the medically needy in nursing homes. It was emphasized at that time that the proposal was not being pulled back because it lacked merit or statutory authority under 1915(b). The state also modified its request concerning the phase out of coverage of its two lowest ICF levels. Based upon discussions with HCFA staff, the state decided that in order to cover individuals presently receiving these levels of care, the state will submit a state plan amendment rather than a waiver proposal to establish different criteria for "continued stay" and "new admissions." Wisconsin continued to press, however, for a waiver to allow it to phase out coverage of ICF 3 and 4 care in compliance which the two step process mandated by state law, which would first eliminate reimbursement for all but those individuals needing such care for chronic mental illness or developmental disabilities.

In addition, the state withdrew its request for a waiver to exempt EPSDT recipients from any copayment requirements, noting that since EPSDT services were a mandatory Medicaid benefit copayments could not be applied to them.

Another Wisconsin proposal submitted as part of the same package requested a waiver to allow the state to impose copayments on mandated services provided to the categorically eligible, although it would not apply them to certain non-institutional or cost effective providers or treatment regimens. A 1981 Wisconsin statute directed the state's Department of Health and Social Services to apply for this and other waivers. The state's application notes that the thrust of this proposal is consistent with the intent of 1915(b)(3), which is designed to encourage the recipient to select the least costly apropriate treatment. The effect these copays might have on recipients' utilization of less costly alternatives is expected to financially enable the state to continue to offer a range of optional services through it sprogram. Cost savings of at least $7 million in expenditures for mandatory services were projected as the result of this waiver request.

A third Wisconsin proposal, also submitted under the statutory authority of 1915(b)(3), sought approval to modify the state's Medicaid dental benefit to provide more catastrophically oriented coverage. A 1981 state statute required Medicaid recipients to pay the first $150 for dental services received in any year, with the state program paying 80% of costs exceeding this amount and the recipient the remaining 20%. This cost sharing requirement would not be applied to EPSDT-screened children, skilled nursing facility residents, and individuals receiving dental care either under a prepayment arrangement or on an inpatient hospital basis. To implement this policy, the state would require a waiver of section 1902(a)(14) of the Social Security Act, which requires that any deductible, copayment or similar cost-sharing charge imposed on a Medicaid benefit must be nominal in amount. Before HCFA could act on this request, the Wisconsin state legislature replaced this approach with a dental benefit which did not require a waiver. The state therefore withdrew this application.

In its May 12, 1982 response to Wisconsin's waiver requests, HCFA informed the state that the only portion of the pending applications which it could approve was that section which sought to exempt prepaid plan enrollees from the state's copayment requirements. The state was informed that the state could under current law effectively exempt institutionalized individuals from copayment requirements by including reimbursement within the overall institutional rate reimbursement for those services on which copayments would otherwise be applied.

The denial of the other aspects of these applications was based on the finding that they did not meet the statutory requirements for waivers under the provisions of section 1915(b). The state was informed of several of the Administration's legislative proposals, which would allow to impose copayments on mandatory services, set these copays at a 'reasonable' rather than a 'nominal' level, and exclude institutionalized recipients from these requirements. The possibility of Wisconsin's submitting its waiver requests under the "research and demonstration" authority of section 1115 of the Social Security Act was also raised.

D. Restricting Recipients to Cost-Effective Providers

Section 1914(b)(4) authorizes the waiver of certain Medicaid state plan requirements in order to allow state agencies to restrict recipients to obtaining services from a provider or

providers that have demonstrated effectiveness and efficiency in providing such services. These providers must meet state plan standards of reimbursement, quality and utilization, provided these standards are consistent with access, quality, and the economic and efficient provision of covered services. The restrictions established by the state cannot discriminate against providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing such services and must not hamper or deter access to emergency services for affected recipients.

A recent U.S. General Accounting Office (GAO) letter report to the DHHS Secretary attempted to gauge the potential cost-savings which might result from restricting Medicaid recipients to low-cost hospitals.* Using data from Maryland and Georgia, GAO estimated that implementation of such an approach could save approximately $1.6 million in the Baltimore area and about $1.7 million in the City of Atlanta. The report identified potential problems associated with such restrictions--for example, increase recipient travel time and refusal of some hospitals to accept large numbers of new Medicaid payments--and also recommended that HCFA require additional information from states implementing these approaches.

Waiver applications have been submitted from four states under the authority of 1915(b)(4).

1. California

On July 10, 1982, the State of California submitted through the Governor's fast track procedure a request for waiver of several state plan requirements under the authority of 1915(b)(4). The state proposes to establish the Selective Provider Contracting Program (SPCP) through which it will contract with selected hospitals in each geographic area of the state for the provision of inpatient services to Medicaid (in California, Medi-Cal) recipients.

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* See letter report to DHHS Secretary from Director, GAO Human Resources Division, entitled "Waiver of Medicaid Freedom-of-Choice Requirement: Potential Savings and Practical Problems" (GAO/HRD-82-90), July 20, 1982.

The development of this program was mandated by recently-passed state legislation (AB 799) which made sweeping changes in the state's Medi-Cal program.*

Under the Selective Provider Contracting Program, hospitals would be given the opportunity to compete for contracts with the state to serve the Medi-Cal population. The state would contract with enough hospitals to provide sufficient capacity for Medi-Cal patients, selecting those hospitals which offer the state the most cost-effective service arrangements. In order to implement the program, a special hospital negotiator will be appointed within the Governor's office to negotiate the rates, terms, and conditions of contracts with hospitals for the state fiscal year beginning July 1982. For subsequent fiscal years, the special negotiator's functions will be assumed by a California Medical Assistance Commission to be established January 1, 1983.

Since the process of contracting with hospitals cannot be carried out simultaneously throughout the states, the negotiator will begin contracting in selected geographic areas, the focus in the first year being on urban areas. The negotiator will initially contact all hospitals in an area to determine their interest in contracting with the Medi-Cal program. After receiving indications of interest, the negotiator will determine whether competitive bidding, negotiations, and/or other methods of procurement would be most appropriate for identifying those hospitals which offer the most cost-effective arrangements for the state.

Factors to be considered in determining with which hospitals to contract will include, among other issues:

- recipient access
- utilization controls
- ability to render quality services efficiently and economically

The negotiator is also required to consider the total amount of funds appropriated for inpatient hospital services when negotiating contracts. A specific group of hospitals may be designated as a negotiating unit.

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* This legislation also authorizes the state to enter into with individual physicians, groups of physicians or other providers contracts which will promote case management and encourage group practices with relationships with hospitals having low unit costs. The state is further authorized to enter into exclusive contracts with counties to provide Medicaid services directly to recipients or which arrange for any or all of the services to be provided by subcontracting with primary care providers, HMOs, insurance carriers, or other entities. As of this writing, no other waiver applications have been submitted by California in order to implement these provisions.

Payment to contracted hospitals may be made on a capitation or prepayment basis, or through the use of other methods which the negotiator determines to be feasible. Reimbursement for hospital inpatient services will take into account hospitals which serve a disproportionate share of low-income patients with special needs. Hospitals may assume all or part of the risk for utilization of services, or cost of services, or both. In order to implement this new payment structure, California has submitted along with its waiver request a state plan amendment to modify its reimbursement methodology. The authority for the state to submit this amendment was provided by section 2173 of the 1981 Omnibus Budget Reconciliation Act.

The hospital contracting requirements will not apply to hospital inpatient service rendered by HMOs and other organized health systems, or state hospitals. Similarly, during the fiscal year beginning July 1982, regionalized specialty hospitals such as children's hospitals would not be required to contract with the Medi-Cal program. Services provided by these hospitals will be reimbursed during this period on the same basis as under the state's present reimbursement methodology.

To assure access to services of adequate quality, the state will contract for services to assure that general acute care contract hospitals are within reasonable geographic distance of all Medi-Cal recipients residing in a service area. The guideline for this "reasonable" distance is identified in the application as 30 minutes driving time for most areas of the state (urban and suburban). Those recipients whose travel time from their home exceeds this guideline will not be restricted to contract facilities. In addition, contracting hospitals will be required to provide admitting privileges to physicians serving Medi-Cal recipients; they cannot deny medical staff membership or clinical privileges for reasons other than a physician's individual qualifications as determined by professional and ethical criteria. Finally, all Medi-Cal recipients will be able to receive services from any hospital in emergency situations, including transportation services in cases where there is the threat of permanent impairment.

In addition to waivers of state Medicaid plan requirements concerning freedom of choice and statewideness, California has also requested a waiver of the following three additional provisions of the Title XIX statute:

- Section 1902 (a)(5) which concerns the identification of a single state agency for Medicaid administration. Waiver of this provision is requested in order to appoint the special hospital negotiator within

the Governor's office as well as establish the California Medical Assistance Commission.

- Section 1902 (a)(13)(A) requires the state to make findings and assurances that its payment levels are adequate to meet the costs which must be incurred by efficiently and economially operated facilities and that they ensure that patients have reasonable access to quality services. The state points out in its application that the contracting process to be set up will utlimately result in payment rates which meet these criteria, but that it cannot at this time make such assurances about payment rates which have yet to be determined. A waiver of the statutory and regulatory requirements concerning assurances, findings and related information concerning these yet to be decided payment levels is thus requested.

- Section 1903 (m)(2) limits to HMOs the application of reimbursement methodologies involving prepaid capitation or any other risk arrangements for inpatient hospital services. California seeks a waiver of this limitation in order to provide the special negotiator and contracting hospitals the greatest possible flexibility in determining reimbursement approaches consistent with obtaining cost-effective services.

At the time of this writing, the U.S. Department of Health and Human Services has not reached a decision on the California waiver application and related state plan amendment.

2. New York

On March 18, 1982, New York State requested a waiver of freedom-of-choice and statewideness requirements in order to limit psychological services to organized mental health clinics certified by the state's Department of Mental Health. New York has determined that the most cost effective and quality-conscious way to provide such services is through an organized system of certified mental health clinics. These organizations provide the assurance of medical supervision and consultation and utilization review mechanism approved by the standard-setting agency. Because the network of certified mental health agencies is not too well developed in some upstate counties and clinic services are not accessible to residential health care facilities statewide, New York--in order to insure the availability of psychological services--proposes to allow the provision of mental health services by private practicing psychologists, subject to prior approval and authorization requirements.

No decision has yet been reached by HCFA on this application.

3. Washington

The State of Washington submitted a waiver application under 1915(b)(4) to implement a prepaid capitation plan for prescription drugs provided to Medicaid recipients residing in certain long-term care facilities. Currently many nursing homes will often deal almost solely with one pharmacy for the provision of drugs. Under the proposed program, a number of these pharmacies will be identified as the exclusive provider for a given nursing home. The state would contract to pay these pharmacies on a monthly payment for each Medicaid recipient in a particular nursing home. Contracts would be let only with large prescription drug providers in the state and only for coverage of the homes they now serve. The benefits expected to result form the closer review of patient drug profiles for the appropriateness of drug treatments are an improvement in patient care as well as savings in program costs. The state estimates that this prepaid capitation reimbursement system for nursing home drugs, initially implemented on a limited scale, will save the Medicaid program $200,000 per year.

Additional information was requested by HCFA on June 3, 1982, and submitted by the state on June 21. No final decision has of yet been reached on this proposal.

4. Wisconsin

One proposal in Wisconsin's February 8, 1982 package of applications requests a waiver of certain long-term care utilization control and survey and certification requirements. The granting of the requested waivers would allow the state continue the same policies and procedures which were first developed and implemented under section 1115 waiver demonstration which is scheduled to end soon. The results of this demonstration indicated that the modifications in federal requirements which Wisconsin sought to extend increased the cost-effectiveness of review activities without adversely affecting the quality of care provided in the state's nursing homes. This waiver request was denied by HCFA on May 12, 1982, on the grounds that there was no statutory authority under 1915(b) to grant waivers for such purposes.

E. Unspecified

Several states either submitted waiver applications under 1915(b) which either did not clearly identify the subsection which was to provide the legislative authority for the wavier

or were not catalogued under a specific subsection by HCFA reviewers. These applications are discussed below.

1. Maine

The State of Maine or November 25, 1981, requested a freedom-of-choice waiver to allow the state to impose a $.50 copayment on prescription drugs for all Medicaid recipients with the exception of nursing home residents. The state was subsequently informed by HCFA that Section 2175 of PL 97-35 provided no statutory authority to provide waivers for copayments.

2. Mississippi

Mississippi requested a waiver of section 1902(a)(8) of the Social Security Act and the regulatory requirements of 42 CFR 442.12(d) and 440.30 in order to allow the state set a limit on the number of Medicaid-reimbursable nursing home beds. This limit would be set at the rates of 100 beds for 1,000 Medicaid eligibles in the state. This waiver application was denied by HCFA on Febraury 18, 1982, because it was deemed not to fall within the scope of any of the subsections of 1915(b) and because it was seen as having an adverse effect on access to services.

3. New Jersey

On February 19, 1982, the State of New Jersey requested a waiver of the requirements for a ten day prior notification of termination of Medicaid services for children in out-of-home placements. This request was submitted by the Department of Human Services' Divison of Youth and Family Services which provides foster care placements for both AFDC and non-AFDC children. The request pointed out the administrative difficulty and logistical problems involved in providing such notices. The state's Division of Medical Assistance and Health Services, which administers the Medicaid program, has indicated its support of the application. This waiver application was denied by HCFA on May 19, 1982.

Table 2.
SUMMARY OF WAIVER REQUESTS SUBMITTED UNDER SECTION 1915(b) OF THE SOCIAL SECURITY ACT

State/Project Title (Date Submitted)	Section Under Which Waivers Sought	Type of Project	Area	Type/Number of Participating Providers	Services to be Provided
California/ On-Lok (6/25/82)	1915(b)(1)	Provide MediCal coverege of services provided by community-based organization	Project site in San Francisco	Community-based comprehensive care provider	A wide range of medical, social, and supportive services for elderly clients
California/ Selective Provider Contracting Program (7/10/82)	1915(b)(4)	Allow the MediCal program to selectively contract for inpatient hospital services with cost-effective facilities	To be phased in statewide, beginning with urban and suburban areas	Stete will contract with sufficient number of hospitals to meet areewide Medicaid needs. Hospitals selected on basis of cost-effectiveness, eccess, etc. HMO and state hospitals do not require contracts, nor do specialty hospitals during first year.	Inpatient hospital services, except in emergency situations
Colorado (1/25/82)	1915(b)(1)	Enrollment of recipients in HMO	Mesa County	Primery cere physicien selected from among providers inRocky Mountain HMO	
Colorado/ Primary Care Physician Case Management Program (6/13/82)	1915(b)(1)	Require recipients to select primary cere physician to serve as case manager	To be phased in statewide	Case manager selected from HMOs, individual physicians, groups of physicians, or clinics	Case managers provide primary cere, arrange for all other acute cere except in emergencies
Connecticut (12/3/81)	1915(b)(3)	Impose larger copay on transportation services than currently allowed			
Hawaii (6/14/82)		Allow stete to provide HMO with list of AFDC eligibles for marketing purposes	Statewide	Kaiser Foundation Health Plan, Inc.	
Maine (11/25/81)		Impose $.50 copay on prescription drugs, excluding nursing home residents	Stetewide		
Massachuetts (7/19/82)	1915(b)(1)	Offer a choice of primery care providers to recipients	Stetewide, except in areas where primery cere sites unavailable	Primary care providers such es HMOs, clinics, neighborhood health centers	Primery cere plus case management for for other services
Massachuetts (7/21/82)	1915(b)(1)	State to contract with e non-profit et-risk coordinating organization to estebliah case management network	City of Boston	Health care providers with which coordineting organization contracts	Vediciaid benefits
Michigan/ Primary Care Sponsor Program (11/5/81)	1915(b)(1)	Enrollment of recipients with primary care physicien	Weyne County (Detroit)	Primery cere physicians participating in project	All acute care except emergency services
Michigan/ Capitated Ambulatory Program (11/25/81)	1915(b)(1)	Offer a choice of primary care providers to recipients	Statewide	Clinics or groups of physicians	Negotiated package (not to include inpatient hospital)
Michigan (12/14/81)	1915(b)(1)	Restrict HMO disenrollment	Statewide		
Mississippi (11/20/81)		Establish limit of 100 Medicaid-reimbursable beds per 1,000 Medicaid-eligible aged, blind or disabled individuals	Stetewide		
New Hampshire (11/10/81)	1915(b)(3)	To provide services to institutionalized recipients even when they exceed limits set for the non-institutionalized. Also, to apply $10 copay on OPD visits and $3.50 copay on each prescription			
New Hampshire (3/20/82)	1915(b)(1)	Require enrollment of AFDC-related recipients in an aree to one HMO	Nashua, N.H. area	One federelly qualified HMO	Same as other group plan enrollees; greeter than that provided other Medicaid recipients

Reimbursement	Recipient Enrollment	Restricted Disenrollment	Anticipated Annual Savings	Financial Incentives To Primary Provider	Status
	Presently 280		Historically from $359 to $1,695 per recipient		Pending
Rates to be negotiated, competitively bid or otherwise determined by special hospital negotiator and area hospitals					
Prepaid capitation ≤ 95% of fee for service average	Mandatory; 9,000 individuals anticipated		$118,000 with initial group; $887,000 annually when project expanded to 5% of Medicaid population		Approved
	Mandatory; recipient must select case managers during period after eligibility determination		Estimated at $3 million	Pool established as incentive for physicians to participate. If savings realized in OPD and inpatient care, FFS reimbursement rates retrospectively increased	Pending
					Disapproved
	Voluntary				Pending
					Disapproved
HMOs at risk, others at FFS plus first year incentives	Voluntary	May change providers with notice		Non-HMO providers share in savings first year, after which at risk for total costs	Pending
State to contract with coordinating organization on risk basis; this organization to contract with providers also on risk basis		Manadatory for AFDC-related recipients in Boston	May change providers during certain periods		Pending
Fee for service plus $3 monthly management fee per enrolled recipient	Mandatory		7-10% on physician, lab, drug, hospital expenses (based on HMO experience)	$3 monthly management fee per recipient	Approved
Prepaid capitation ≤ 100% of fee-for-service average	Voluntary	May change providers with notice	If comparable to HMO experience, 20% reduction in inpatient hospital expenditures	State will share inpatient hospital savings with primary provider	Approved
		Enrolled recipients restricted from leaving HMO for 3 months following first 30 days			Pending
					Disapproved
					Disapproved
	Mandatory for 2,000 AFDC-related recipients in HMO catchment area	Termination without cause not permitted after enrollment			Approved

Table 2. (Continued)

State/Project Title (Date Submitted)	Section Under Which Waivers Sought	Type of Project	Area	Type/Number of Participating Providers	Services to be Provided
New Jersey (2/19/82)		To not require 10 day prior notification of termination of Medicaid benefits to children in out-of-home placements	Statewide		
New York (2/18/82)	1915(b)(1)	Restrict HMO disenrollment	Statewide		
New York (3/18/82)	1915(b)(4)	Limit provision of psychological services to mental health clinics	Statewide, although in areas lacking these clinics, services could be provided by private psychologists	Mental health clinics certified by state's Dept. of Mental Health	
Pennsylvania (3/4/82)	1915(b)(1)	Restrict high utilizers to primary care physician who authorizes services	Statewide	Primary care physicians willing to serve as case managers	All services except dental, emergency, and transportation must be authorized
Pennsylvania/ Primary Care Capitated Program (4/27/82)	1915(b)(1)	Enrollment of recipients with primary care providers	4 sites across state	4 primary care centers	All services under state Medicaid plan, except LTC
Utah (11/2/81)	1915(b)(1)	Recipients to select primary care provider from 3 alternatives	Statewide	Primary care provider to be selected from: —non-certified IPA HMO; —certified HMO; or —individual primary care physician	
Washington (10/16/81)	1915(b)(1)	Waiver of certain nursing home utilization control/ review activities			
Washington (10/22/81)		Waiver to impose a $5 copayment on emergency room and OPD visits for all except institutionalized Medicaid recipients			
Washington (4/14/82)	1915(b)(4)	Establish prepaid capitation plan for prescription drugs provided to nursing home recipients		Large prescription drug providers currently serving nursing homes	Prescription drugs
Wisconsin (2/8/82)	1915(b)(1)	Allow phased implementation of program to require recipients to enroll in prepaid health plan	To begin in 4 counties with statewide phase-in	Physicians participating in contracted HMOs or other prepaid capitation arrangements	Acute care including arrangements for emergency care
Wisconsin (2/8/82)	1915(b)(1)	Community mental health boards would provide overall case management for mental health care	Statewide		Inpatient and outpatient psychiatric services
Wisconsin (2/8/82)	1915(b)(3)	Would 1) exempt certain recipient groups from state's copayment requirements, 2) provide additional benefits to medically needy nursing home residents, and 3) phase out two lowest levels of ICF care	Statewide		
Wisconsin (2/8/82)	1915(b)(3)	Would impose copayments on certain mandatory services to promote utilization of cost-effective services	Statewide		
Wisconsin (2/8/82)	1915(b)(4)	Would revise long-term care facility utilization control and survey and certification requirements	Statewide		
Wisconsin (2/8/82)	1915(b)(3)	Would change state's dental coverage to more catastrophically-oriented benefit with $150 deductable and 20% cost-sharing on excess	Statewide		All dental care, except that provided on inpatient basis or to EPSDT recipients, nursing home residents, or individuals in prepaid plans

Reimbursement	Recipient Enrollment	Restricted Disenrollment	Anticipated Annual Savings	Financial Incentives To Primary Provider	Status
					Disapproved
	-	Enrolled recipients restricted from leaving HMO for 5 months following first 30 days			Pending
					Pending
Fee-for-service plus $10 monthly management fee per enrolled recipient	Mandatory for individuals identified as high utilizers	Restricted	$2.2 million (~$1,000 per enrolled recipient)	$10 monthly management fee per recipient	Pending
Capitated rate @ 95% of fee for service average	Voluntary; 4,000 enrolees anticipated	Disenrollment restricted after first 30 days			Approved
	Mandatory	No			Approved
					Disapproved
					Disapproved
					Pending
Capitated prepayment	Recipients in pilot counties must select from available prepayment options	In areas where only one prepayment plan available, recipients may "opt out" of plan	$20 million		Approved
			$1 million	Local board responsible for portion of inpatient hospital costs	Disapproved
			$8 million		Only that portion of waiver request seeking to exempt HMO enrolled from copayment was approved
			$7 million		Disapproved
			$7 million		Disapproved
			$7 million		Withdrawn by state

Table 3

PROVISIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT FOR WHICH WAIVERS HAVE BEEN SOUGHT UNDER SECTION 1915(b)

	1902(a)(1) Statewideness	1902(a)(10) Comparability of Services	1902(a)(23) Freedom of Choice	1903(m)(2)(A)(i) Prohibits Risk Arrangement With Non-Federally Qualified HMO	1903(m)(2)(A)(ii) Limits Meidicare/ Medicaid Recipients to 75% of Prepaid Plan Membership	1903(m)(2)(A)(vi) Permits Recipients To Disenroll from HMO Without Cause	Other
California (6/23/82)	X	X	X	X	X		
California (7/10/82)	X		X				1902(a)(5) 1902(a)(13)(A) 1903(m)(2) (no specific subsections)
Colorado (1/25/82)	X		X				
Colorado (6/15/82)	X		X				
Connecticut (12/3/81)							1902(a)(14)
Hawaii (7/14/82)							1902(a)(7)
Maine (11/25/81)		X					
Massachuetts (7/19/82)	X		X	X			
Massachuetts (7/21/82)	X		X		X		1902(e)(2)
Michigan (11/5/81)	X		X				1902(a)(7)
Michigan (11/25/81)			X		X		
Michigan (12/14/81)						X	
Mississippi (11/20/81)							1902(a)(8)
New Hampshire (11/10/81)							

New Hampshire (3/26/82)	X	X	X			X	
New Jersey (2/19/82)							
New York (2/18/82)						X	
New York (3/19/82)	X		X				
Pennsylvania (3/4/82)	X		X				1903(m) subsection not specified
Pennsylvania (4/27/82)	X		X	X	X	X	
Utah (11/2/81)			X				
Washington (10/10/81)							
Washington (10/22/81)							
Washington (4/14/82)			X				
Wisconsin (2/8/82)							
a. Copay Exceptions and Service Phaseout		X					
b. Cost Sharing for Mandatory Services							1902(a)(14)
c. Catastrophic Dental Coverage							1902(a)(14)
d. HMO Lock-in			X			X	
e. Mental Health Case Management			X				
f. LTC UC and Survey and Certification							1902(a)(4,6,9,26,28,31)
Totals	11	4	16	3	4	5	17

IV. Other 'Competition' Demonstrations

In addition to those waiver projects granted under the authority of 1915 (b), the Health Care Financing Administration has also recently awarded a number of related demonstrations under the authority of Section 1115 of the Social Security Act.

On March 1, 1982, HCFA published a special solicitation in the Federal Register (47 FR 8740-8748) which offered states the opportunity to develop and implement demonstration projects designed to enhance competition in state Medicaid programs. Ten states submitted a total of fifteen proposals in response to this solicitation. Demonstration grants totaling $900,000 in the first year were awarded ultimately to five states to develop and implement projects to increase competition in their Medicaid programs. The demonstrations will generally operate for four years, with a one-year planning phase and a three-year demonstration phase. Brief descriptions of the approved projects are presented below.

Florida received funds to develop an Alternative Health Plan Project which includes four modules, each designed to increase competition in the state's Medicaid program. The modules are:

- Competitive Alternative Plans - the state will issue an RFP to HMOs in five counties to accept capitated reimbursement for Medicaid recipients. Thirty thousand recipients are targeted to enroll. Plans will be expected to offer expanded benefits, shared savings, and guaranteed eligibility.

- Recipient Case Management in a Fee-for-Service System - the state will implement program in three counties to target overutilizers and high risk cases using an advanced surveillance system.

- AHP for the Frail Elderly - the state will award risk contracts to provide comprehensive care to eligible nursing home enrollees. The project will coordinate long term care support services (e.g., adult day care, case management, respite care, homemaker services) to provide alternatives to institutionalization.

- Medical Care Vouchers - the state will offer a Medicaid voucher to 1,000 beneficiaries using a broker to advise in decisionmaking. The voucher will be set at 95 percent of the fee-for-service amount.

The State of Minnesota was awarded a grant to establish Medicaid Voucher Demonstration. Under this project, the state will develop and implement a consumer choice model which includes a wide range of prepaid health plans. Providers will be reimbursed some percentage (90-95%) of the projected average per capita cost for Medicaid recipients with a health status adjustment for high risk eligibles. The state will also contract with an independent broker to handle the marketing of competing plans.

The State of Missouri will implement a Prepaid Health Demonstration Project through which the state will enroll approximately 5,000 AFDC eligibles in the Kansas City area in alternative health plans. These plans will be reimbursed on a capitated basis and will assume limited risk. Recipients will be provided enrollment incentives including cash rebates, increased benefits, and guaranteed eligibility. Marketing of these alternative plans will be done in the state welfare office using slide presentations and standardized written materials.

The State of New Jersey has received funds to develop a statewide Medicaid Competition Demonstration which will include broker and case management components. The case management portion will focus on direct primary care delivery and referrrals for ancillary services for all noninstitutionalized recipients. The case managers will be at risk for all services up to a maximum amount. This maximum was established to address concerns about adverse selection.

The state will also contract with broker organizations which will enroll a wide range of providers/case managers and will be responsible for conducting marketing, consumer grievance procedures, and quality of care monitoring.

The State of New York will enter into a contract with Monroe County under which the county will accept a fixed payment for the delivery of health care to all Mediciad recipients in the county. The county will establish a separate organizational entity called MediCap Plan, Inc. to administer the program and will offer recipients various health care options, including:

- existing HMOs
- an insurance package to be offered by Rochester Blue Cross and Blue shield which is intended to increase access to primary care providers; and
- use of solo or group practitioners under contract.

Savings are projected to be at least 5 percent of existing fee for service costs.

V. Future Waiver Activity and Recent Legislative Changes

While the number of waiver applications submitted under 1915(b) has to date been substantial, there are indications that several states may be interested in submitting additional waiver requests in the not too distant future.

As noted earlier in this paper, legislation recently passed in the State of California authorizes the state to enter into contracts promoting case management with physicians, groups of physicians, or other providers. This same statute (AB 799) also authorizes the state to enter into exclusive contracts with counties to provide Medicaid services directly to recipients or to arrange for any or all of the services to be provided by subcontracting with primary care providers, HMOs, insurance carriers, or other entities. Requests for waiver would have to be submitted by the state in order to implement these provisions.

The Tennessee Department of Health is involved in preliminary discussions with the state's Association of Primary Care Centers, a non-profit organization which has received funds from several foundations to establish a separate corporate entity with which the state can contract for the provision of services to its Medicaid population.

The organizational arrangements which are currently under discussion in Tennessee are similar to those described in Massachusetts' proposed arrangement with the Commonwealth Health Care Corporation (see page 13). The central organization would be paid a capitated fee by the Tennessee Medicaid Agency for coverage of a yet-to-be determined set of services for certain AFDC-related Medicaid eligibles. That entity would then pay a certain amount to participating centers for each recipient for which they would provide case management and primary care services. Another amount would be set aside by the central organization to pay for specialist care for which the primary care center would provide referrals.

The discussions of the fiscal incentives to be employed at this point have included drawing from the primary care center's account when specialty care claims exceed their budgeted level, and the centers' sharing in the savings when specialty care expenditures are less than projected. The establishment of limits is being examined to control against the primary care centers being exposed to excessive profits or losses.

The operation of this case management program would not be scheduled to begin until early 1983, with a phased-in implementation period. It is anticipated that by the end of its first full year of operation, five to seven primary care centers would be participating in the program, each with about 1,000 AFDC-related recipients enrolled.

The content of future waiver applications, as well as the final decisions yet to be reached by DHHS on pending waiver applications, may well be affected by an imminent change to be made in the statutory language of section 1915(b).

As noted earlier in this report, a bill recently passed by the U.S. Congress on August 19, 1982 and soon to be signed by the President--H.R. 4961, The Tax Equity and Fiscal Responsibility Act of 1982, which provides for federal tax increases and spending cuts resulting from the FY 1983 budget reconciliation process--includes a provision which deletes from section 1915(b) the DHHS Secretary's authority to waive the provisions of section 1903(m) of the Medicaid statute. This latter section allows states to contract on a risk-basis only with federally qualified HMOs or with other HMOs which the state determines: (1) will make services accessible to its Medicaid enrollees to the same extent that they are available to Medicaid recipients not enrolled in the plan; and (2) have made satisfactory provisions against the risk of insolvency and, in the event of insolvency, will not hold recipients liable for payment for services.

Section 1903(m)(2)(A) further stipulates that states cannot contract on an at-risk basis with any entity which provides inpatient hospital services and any other mandatory Medicaid service (except rural health clinic services) or any three of these services, unless that entity:

- meets the requirements for an HMO, as described above, or has been provisionally determined to be one by a state;
- has less than 75% of its prepaid membership participating in Medicare and/or Medicaid;
- provides services in accordance with a contract it has with a state and receives payments determined on an actuarially sound basis;
- allows DHHS or the state the right to audit its books;
- does not have enrollment, reenrollment, or disenrollment policies which discriminate against individuals on the basis of their health status or requirements for health care;

- allows individuals to terminate their coverage after their first month in the plan; and
- provides for coverage of out-of-plan emergency services.

The section removing the Secretary's authority to waive the provisions of 1903(m) states that this restriction would not apply to any waivers which were granted and the arrangements covered by the waiver were in place prior to August 10, 1982. As indicated in Table 3 on page 38, eleven applications from seven states had requested a waiver of some portion of 1903(m). Of these, four (Michigan, New Hampshire, Pennsylvania, and Wisconsin) had been approved prior to August 10.

How the remaining seven applications and any new submissions which propose at-risk arrangements with non-HMOs will fare will depend upon the interpretation of language contained in the conference report accompanying H.R. 4961. This report states that:

> "It is understanding of the conferees that the types of entities subject to the requirements of section 1903(m) would not include contractual arrangements between the State and an individual physician, or a group of physicians, under which (1) case management is the primary purpose; (2) hospital services are not provided directly by, or under contract for payment to, such physician or physician group; (3) the physician or physician group receives at least 25% of its gross revenues from non-Medicaid and non-Medicare patients (through fee-for-service or other reimbursement methods); (4) the Medicaid revenues that the physician or physician group would otherwise receive from the arrangement will not increase more than 20% as a result of a decrease in the use by beneficiaries under management of hospital and other covered services; and (5) primary care services are available on a 24-hour basis."*

While the conference report may not provide help for the pending New York and Michigan applications, which solely seek to waive the 1903(m) requirement that individuals be allowed to terminate their enrollment in HMOs after their first month in the plan, the impact of this language on proposals such as that submitted by Massachusetts is yet unclear. That state seeks approval to contract on an at-risk basis with a central coordinating organization, which in turn will then contract on a risk basis with separate provider organizations for the delivery of services.

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* Conference Report to Accompany H.R. 4961, Tax Equity and Fiscal Responsibility Act of 1982, U.S. House of Representatives, August 17, 1982, pp. 440-41.

What the effect this change in the statutory language of 1915(b) will have on the design of future waiver proposals is also uncertain. A more important question, however, is what the effect of the overall waiver program will be on the cost and utlilization of Medicaid services, as well as on the access to and quality of such services. While it is much too early to evaluate the effectiveness of the program, based upon the number and nature of applications submitted to date, what is clear is that states have drawn upon the increased flexibility it provides with the expectation that it may provide at least a partial solution to the problems plaguing the Medicaid program.

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